LETTERS TO THE EDITOR

- *The British Heart Journal welcomes letters commenting on papers that it has published within the past six months.*
- *All letters must be typed with double spacing and signed by all authors.*
- *No letter should be more than 600 words.*
- *In general, no letter should contain more than six references (also typed with double spacing).*

10 year review of cardiac tumours in childhood

SIR,—In their review Abushaban and colleagues (*Br Heart J* 1993;70:166–9) found six cases of cardiac tumours in childhood. They conclude that such tumours are extremely rare and that they have an excellent outcome. We identified 15 children with rhabdomyomas who were symptomatic in infancy: 13 had presented by the age of one month.[1] Our results suggest that presentation in infancy, rather than being "uncommon", is probably the rule. Rhabdomyomas usually regress after birth so they are indeed more likely to present in infancy than later.

Two thirds of our patients were male; Harding *et al* in a review of 355 reported cases reported a similar sex distribution.[2]

Abushaban *et al* may have been fortunate in their patients' outcome: five (33%) of the children we identified had died within one month of birth, three within 3 days. Only one of their four patients with rhabdomyomas had tuberous sclerosis at follow up: whereas 12/15 (80%) of our patients did. It can be difficult to diagnose tuberous sclerosis in the early months of life (when the cardiac lesions are most likely to present). All children with cardiac rhabdomyomas should have careful investigation with prolonged follow up. The report of the isolation of one of the genes for tuberous sclerosis means that molecular analysis may in future allow diagnostic proof of tuberous sclerosis.[3]

DAVID W WEBB
ANTONIA CLARKE
ROD THOMAS*
JOHN P OSBORNE
Bath Unit for Research into Paediatrics, and The Cardiac Centre, Royal United Hospital, Combe Park, Bath*

1 Webb DW, Thomas RD, Osborne JP. Cardiac rhabdomyomas and their association with tuberous sclerosis. *Arch Dis Child* 1993;68: 367–70.
2 Harding CO, Pagon RA. Incidence of tuberous sclerosis in patients with cardiac rhabdomyomas. *Am J Med Genet* 1990:37: 443–6.
3 The European Chromosome 16 Tuberous Sclerosis Consortium. Identification and characterisation of the tuberous sclerosis gene on chromosome 16. *Cell* 1993;75: 1305–15.

Radiation hazards to the cardiologist

SIR,—Professor Camm and his committee have provided an excellent review of the radiation hazards to cardiologists (*Br Heart J* 1993;70:489–96). It covers comprehensively the hazards involved in interventional procedures: but cardiologists may also be exposed to radiation when they perform nuclear cardiology procedures. The hazard to the operator in these procedures is very small compared with that during invasive procedures; none the less, training in nuclear cardiology is an essential part of cardiology training.[1] Experienced cardiologists and those in training must know how to handle unsealed radioactive sources in order to minimise hazard to themselves and to others. Though most cardiologists do not perform both invasive and nuclear procedures themselves, some do.

Consideration of the radiation hazards during nuclear cardiology procedures would therefore have added to the completeness of the review. The British Nuclear Cardiology Group would be happy to contribute to any future review.

RICHARD UNDERWOOD
Past Chairman, British Nuclear Cardiology Group, National Heart & Lung Institute, Dovehouse Street, London SW3 6LY
JOHN CAPLIN
Current Chairman, British Nuclear Cardiology Group, Hull Royal Infirmary, Anlaby Road, Hull HU3 2KZ.

1 Joint Training and Manpower Group representing the Specialty Advisory Committee and the Cardiology Committee of the Royal College of Physicians of London, and the British Cardiac Society. Proposals for a new training programme for cardiology. *Br Heart J* 1990;63:317–20.

Pathogenesis of oedema in chronic severe anaemia: studies of body water and sodium, renal function, haemodynamic variables, and plasma hormones

SIR,—I was interested to read the paper by Anand and his colleagues on the pathogenesis of oedema in chronic severe anaemia (*Br Heart J* 1993;70:357–62) that very nicely shows the mechanism for the development of fluid retention and congestion in patients with increased cardiac output. The low peripheral resistance associated with anaemia reduces the blood pressure. This directly reduces salt and water excretion and this reduction will be exacerbated by reflex stimulation of the sympathetic nervous system and renin-angiotensin-aldosterone system as the blood pressure is perceived to be "threatened". I believe a similar mechanism operates in the postpartum heart failure syndrome of Northern Nigeria. In 1979 I and others put forward an almost identical explanation to explain how women with normal or high cardiac outputs, normal left ventricular function, and apparently normal renal function could develop fluid retention and severe circulatory congestion.[1] Like Anand *et al* we suggested that low peripheral resistance and blood pressure (induced in Nigeria by excessive heating due to lying on "hot" beds for over 40 days) caused the kidneys to retain salt and water even in the face of a high salt intake. Furthermore, in a *Lancet* hypothesis article[2] I suggested that this was a mechanism that might explain the increased tendency for oedema formation in hotter climates. The same mechanism may be operating in patients with postpartum heart failure elsewhere. More recently a paper from Brazil reported that patients with peripartum cardiomyopathy had normal or high cardiac index, nearly normal left ventricular ejection fractions, and lower systemic vascular resistance than patients with dilated cardiomyopathy.[3]

All these examples therefore confirm the central hypothesis that it is a low or "threatened" arterial pressure that is the main stimulus for salt and water retention in heart failure[4] not only in high-output failure caused by excessive vasodilatation but also in low-output failure caused by poor myocardial function.

JOHN E SANDERSON
Department of Medicine, Chinese University of Hong Kong, Prince of Wales Hospital, Shatin, Hong Kong

1 Sanderson JE, Adesanya CO, Anjorin FI, Parry EHO. Postpartum cardiac failure-heart failure due to volume overload? *Am Heart J* 1979;97:613–21.
2 Sanderson JE. Oedema and heart failure in the tropics. *Lancet* 1977;ii:1159–61.
3 Marin-Neto JA, Maciel BC, Urbanetz LL, Gallo L, Almeida-Filho OC. High-output failure in patients with peripartum cardiomyopathy: comparative study with dilated cardiomyopathy. *Am Heart J* 1991; 121:134–40.
4 Harris P. Role of arterial pressure in the oedema of heart disease. *Lancet* 1988;i: 1036–8.

BRITISH CARDIAC SOCIETY NEWSLETTER

While the difficulties of implementing the Calman proposals continue to occupy a considerable amount of time, another initiative is beginning to surface—namely, continuing medical education (CME). The joint declaration from the Royal Medical Colleges and their faculties makes a clear commitment to the introduction of CME for all doctors. The British Cardiac Society is cooperating with the Royal Colleges in discussing the quantity and quality of CME. It is likely to require a commitment from individual doctors to participate both in internal CME at their normal place of work and a requirement to attend a certain amount of CME externally. The programmes for CME should be developing over the next year or so and the British Cardiac Society is keen to participate in the process.

Your President was invited to the 60th Anniversary Meeting of the Netherlands Cardiac Society in April in Amsterdam, and contributed to the programme reviewing the development of cardiac surgery in Europe.

British Nuclear Cardiology Group
John Caplin writes: "The British Nuclear Cardiology Group held a very successful meeting on 1 November 1993 at the Cardiothoracic Institute attached to the Royal Brompton National Heart and Lung Hospital. The meeting was over-subscribed, with at least 180 people attending.

Speakers included Geoffrey Leppo from the United States, who spoke about myocardial perfusion imaging. Other speakers included Stephen Valley, Elizabeth Prvulovich, Michael Norell, Richard Underwood, and Dudley Pennell.

The British Nuclear Cardiology Group will be involved in the British Nuclear Medicine Society meetings and will also be holding a 90 minute session at the forthcoming British Cardiac Society meeting in Torquay. Speakers there will include Peter Jarrett and Andrew McLeod. One half of the session will be devoted to 'Everything you wanted to know about nuclear cardiology in 45 minutes'."

Society of Cardiological Technicians
Michael Martin writes: "The Society of Cardiological Technicians was set up to encourage closer cooperation between cardiologists and cardiology technicians, and to discuss and advise on matters of mutual interest.

In the past 12 months there have been a number of important issues. The development of National Vocational Qualifications in technical cardiology (BCS Newsletter, March 1993) continues to pose problems: the gestation has been positively elephantine. As yet the end of the process is not in sight but the Committee will continue to press for standards that are workable and relevant to maintaining comprehensive technician training.

The Society of Cardiological Technicians is preparing an application to be approved as a profession allied to medicine, and the Committee think it is vital that this initiative receives vigorous support from the British Cardiac Society.

Several further issues, such as non-medically supervised exercise testing, have led to lively debate, which will no doubt continue to the benefit of technicians and cardiologists alike."

European Society of Cardiology
Philip Poole-Wilson writes: "The Congress of the European Society of Cardiology in 1996 takes place in Birmingham from 25 August to 29 August. ECOR and the ESC are organising the meeting and have already undertaken most of the preliminary work. The British Cardiac Society is the host. Organisers are not the only source of good ideas, and if members do have suggestions to make this congress a success, please transmit them to the officers of the British Cardiac Society or to me."

D JOHN PARKER
President, British Cardiac Society

JOHN G F CLELAND
Assistant Secretary, British Cardiac Society,
9 Fitzroy Square,
London W1P 5AH